

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JUN 17 1960 149

=60-023084

3068

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u> 30 Years   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>                                 |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Length of stay in 1b <u>8 hours</u>   |  |  |  | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |   |  |
| c. FULL NAME OF (If NOT in hospital, give location) <u>General Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |  |  | d. STREET ADDRESS <u>3802 N. Main</u> (If location) <u>3522 Walnut</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>            |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>NORMAN</u> Middle <u>A.</u> Last <u>Buck</u>   |  |  |  | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>5</u> Year <u>60</u>   |  |   |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>white</u>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>          |  | 8. DATE OF BIRTH <u>2/1/04</u>                                    |  |
| 9. AGE (last birthday) <u>56</u>   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   |  | IF UNDER 24 HR<br>Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic Felds Trucking</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Leasing</u>   |  | 11. BIRTHPLACE (City and state or country) <u>Arkansas</u>        |  |
| 12. CITIZEN OF WHAT COUNTRY <u>U S A</u>   |  |  |  |  |  |   |  |
| 13a. FATHER'S NAME <u>Arthur Buck</u>  |  |  |  | 13b. MOTHER'S MAIDEN NAME <u>Hattie Rice</u>   |  |   |  |
| 14. NAME OF HUSBAND OR WIFE <u>Maria Buck</u>  |  |  |  | Address <u>3802 N. Main</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>495-05-1959</u>   |  | 17. INFORMANT <u>Maria Buck</u>                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>  </u><br>DUE TO (c) <u>  </u>   |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old Cerebral Vascular Accident</u>  |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>  |  | Month, Day, Year <u>6-5-60</u>   |  |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>12:30 P.M.</u> |  | 20f. CITY, TOWN, OR LOCATION <u>10:20 P.M.</u>   |  | COUNTY <u>6-5-60</u> STATE <u>  </u>                              |  |
| 21. I attended the deceased from <u>6-5-60</u> to <u>6-5-60</u> and last saw him alive on <u>6-5-60</u><br>Death occurred at <u>10:20</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |  |  |  |   |  |
| 22a. SIGNATURE <u>L. Dwyer</u> (Degree or title) <u>Med.</u>   |  |  |  | 22b. ADDRESS <u>2400 Perry City</u>  |  | 22c. DATE SIGNED <u>6/7/60</u>                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE <u>6/8/1960</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>   |  | 23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u> |  |
| 24. FUNERAL DIRECTOR <u>D.W. Newcomers Sons</u> ADDRESS <u>1331 Brush Creek Blvd.</u>  |  |  |  | 25. DATE RECD. BY LOCAL REG. <u>6-8-60</u>   |  | 26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>                    |  |
| Kansas City Missouri (Licensed Embalmer's Statement on Reverse Side)   |  |  |  |  |  |   |  |

DOCUMENT

MEDICAL CERTIFICATION

L. Dwyer

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Chestnut Brown*

Licensed Embalmer No. *492*

P. O. Address

*HE No*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co  
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.